



Child Health and Maternal Health

**Who's got the power?
Transforming health systems
for women and children**

Summary version



Achieving the Millennium Development Goals

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Task Force on Child Health and Maternal Health
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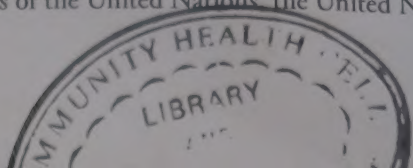
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Preface

What will it take to meet the Millennium Development Goals on child health and maternal health by 2015, including the targets of two-thirds reduction in under-five mortality, three-quarters reduction in the maternal mortality ratio, and the proposed additional target of universal access to reproductive health services? The final task force report, summarized here¹, reflects more than two years of discussions and meetings of an extraordinary group of experts in child health, maternal health, and health policy, who were charged with responding to this question.

The task force agreed on several principles from the very start. First, although achieving the Goals depends on increasing access to a range of key technical interventions, simply identifying those interventions and calling for their broad deployment is not enough. Answering “What will it take?” requires wrestling with the dynamics of power that underlie the patterns of population health in the world today.

Second, those patterns reveal deep inequities in health status and access to healthcare both between and, equally important, within countries. Any strategy for meeting the quantitative targets must address inequity head-on.

Third, although child health and maternal health present very different challenges – indeed, often pull in different directions – they are also inextricably linked. The task force made a clear decision from the start that it would stay together as one task force and build connections between the two fields. And there is common ground: all task force members were convinced that the fundamental recommendation of the joint task force must be that widespread, equitable access to *any* health intervention – whether primarily for children or

¹ The full report is available from the Millennium Project website
[www.unmillenniumproject.org/documents/ChildHealthEbook.pdf].

for adults – requires a far stronger health system than currently exists in most poor countries. Moreover, only a profound shift in how the global health and development community thinks about and addresses health systems can have the impact necessary to meet the Goals.

This report seeks to capture the texture of the task force's discussions and major conclusions. It does not review the entire field of child or maternal health, nor does it cover every important area of work or express every legitimate viewpoint on every issue. It most certainly does not offer a blueprint for all countries. Instead, it tries to show a way forward by posing the question that must be asked, answered, and confronted at every level of any serious strategy to change the state of child health, maternal health, and reproductive health in the world today, namely, "Who's got the power?" This report aims to show how the power to create change can be marshalled to transform the structures, including the health systems, that shape the lives of women and children in the world today.

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The principal recommendations of the Task Force on Child Health and Maternal Health

1. Health systems: Health systems, particularly at the district level, must be strengthened, with priority given to strategies for reaching the child health and maternal health Goals.

- Health systems are key to the sustainable and equitable delivery of technical interventions.
- Health systems should be understood as core social institutions that are indispensable for reducing poverty and advancing democratic development and human rights.
- To increase equity, policies should strengthen legitimacy of well governed states, prevent excessive segmentation of the health system, and enhance the power of the poor and marginalized to make claims for care.

2. Financing: Strengthening health systems will require considerable additional funding.

- Bilateral donors and international financial institutions should substantially increase aid.
- Countries should increase allocations to their health sectors.
- User fees for basic health services should be abolished.

3. Human resources: The health workforce must be developed according to the goals of the health system with the rights and livelihoods of the workers addressed.

- Any health workforce strategy should include plans for building a cadre of skilled birth attendants.
- Regulations and practices, including those related to 'scope of profession,' should be changed to empower a wider range of health workers to perform life-saving procedures safely and effectively.

4. Sexual and reproductive health and rights: Sexual and reproductive health and rights are essential to meeting all the MDGs, including those on child health and maternal health.

- Universal access to reproductive health services should be ensured.
- HIV/AIDS initiatives should be integrated with programs on sexual and reproductive health and rights.
- Adolescents should receive explicit attention with services that are sensitive to their increased vulnerabilities and designed to meet their needs.
- In circumstances where abortion is not against the law, abortion services should be safe. In all cases, women should have access to quality services for the management of complications arising from abortion.
- Governments and other relevant actors should review and revise laws, regulations, and practices – including those on abortion – that jeopardize women's health.

5. Child mortality: Child health interventions should be scaled up to 100 percent coverage.

- Child health interventions should be increasingly offered within the community, backed up by the facility-based health system.
- Child nutrition should receive additional attention.
- Interventions to prevent neonatal deaths should receive increased investment.

6. Maternal mortality: Maternal mortality strategies should focus on building a functioning primary healthcare system, from first referral-level facilities to the community level.

- Emergency obstetric care must be accessible for all women who experience complications in pregnancy and childbirth.
- Skilled birth attendants, whether based in facilities or communities, should be the backbone of the system.
- Skilled attendants for all deliveries must be integrated with a functioning district health system that supplies, supports and supervises them adequately.

7. Global mechanisms: Poverty-reduction strategies and funding mechanisms should support and promote actions that strengthen equitable access to quality healthcare and do not undermine it.

- Global institutions should commit to long-term investments.
- Restrictions to funding of salaries and recurrent costs should be removed.
- Donor funding should be aligned with national health programs.
- Health stakeholders should participate fully in policy development and funding plans.

8. Information systems: Information systems are an essential element in building equitable health systems.

- Indicators of health system functioning must be developed and integrated into policy and budget cycles.
- Health information systems should provide appropriate, accurate and timely information to inform management and policy decisions.
- Countries must take steps to strengthen vital registration systems.

9. Targets and indicators: The MDG targets and indicators should be modified as follows:

- All targets should be framed in equity-sensitive terms.
- Universal access to reproductive health services should be added as a target to MDG 5.
- All targets should have an appropriate set of indicators as shown in Table 1.

Table 1.
Existing and
proposed targets and
indicators for the child
health and maternal
health MDGs

Proposed
modifications appear in
italics

Goal	Target	Indicators
Goal 4: Reduce child mortality	Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate, <i>ensuring faster progress among the poor and other marginalized groups.</i>	<ul style="list-style-type: none"> • Under-five mortality rate • Infant mortality rate • Proportion of 1-year-old children immunized against measles • Neonatal mortality rate • Prevalence of underweight children under 5 years of age (see MDG 1 indicator)
Goal 5: Improve maternal health	Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio, <i>ensuring faster progress among the poor and other marginalized groups.</i> <i>Universal access to reproductive health services by 2015 through the primary healthcare system, ensuring faster progress among the poor and other marginalized groups.</i>	<ul style="list-style-type: none"> • Maternal mortality ratio • Proportion of births attended by skilled health personnel • Coverage of emergency obstetric care • Proportion of desire for family planning satisfied • Adolescent fertility rate • Contraceptive prevalence rate • HIV prevalence among 15–24-year-old pregnant women (see MDG 6 indicator)

Acknowledgments

The coordination team of the task force extends its deepest thanks to the task force members, who contributed their insight, experience, and wisdom every step of the way. The members served on the task force in their personal capacity. We are grateful to several colleagues outside of the task force for significant contributions to the report, including Eugenia McGill and Giulia Baldi. We also benefited from a series of papers commissioned by the task force, whose authors are too numerous to mention, but whose contribution is no-less outstanding for that.

The task force had the incredible good fortune to connect its work with several major global health research projects. The child health work drew on the findings of the Bellagio Study Group on Child Survival, the Child Health Epidemiology Research Group, and the Multi-Country Evaluation of Integrated Management of Childhood Illnesses (IMCI). Members of the Global Equity Gauge Alliance (GEGA) prepared a series of commissioned papers and presented at the task force meeting in South Africa. The work of the Rights and Reforms Project, based at the Women's Health Project in South Africa, informed our deliberations on health systems and health financing. Close communication with the Joint Learning Initiative on Human Resources for Health provided important background for our thinking on the health workforce. The Maternal and Neonatal Health and Poverty project of the World Health Organization collaborated with us in jointly commissioning an important review of the literature on obstetric referral and participated in our South Africa meeting. The Special Rapporteur on the Right to Health, Paul Hunt, and his staff consulted on human rights issues and also participated in our South Africa meeting.

We would also like to thank warmly our many colleagues from around the world who tracked down data, provided comments and suggestions on the task force's background paper and interim report, and for comments on early drafts

of the final report. We are particularly grateful for the work of our three external reviewers – Marge Berer, Di McIntyre, and Peter Uvin – who carefully read and commented extensively on the draft.

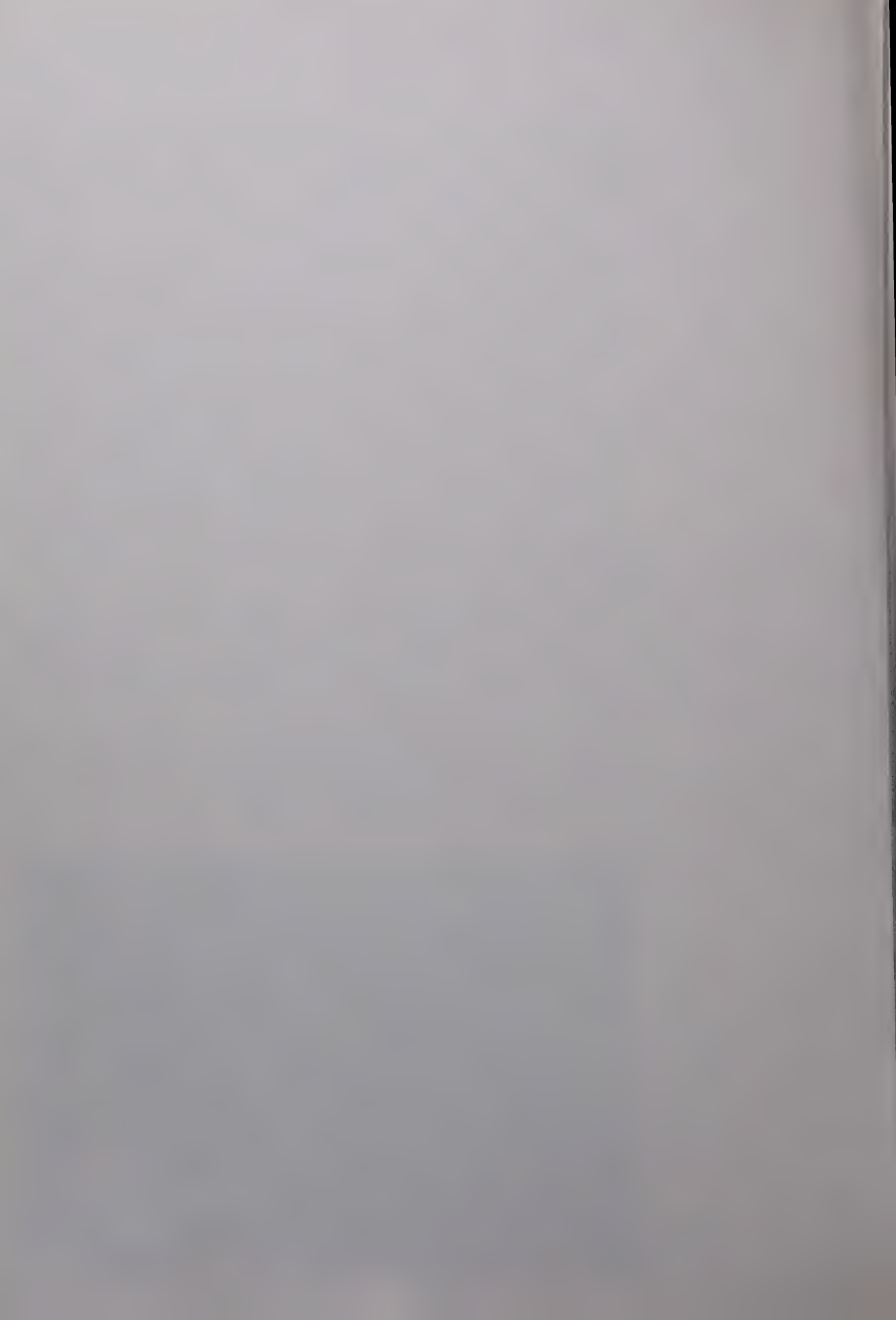
Our task force meetings in Bangladesh and South Africa were enlivened by presentations and participation of colleagues from non-governmental organizations and various multilateral agencies, although we lack space to thank them individually. We thank the Bangladesh Rural Advancement Committee for hosting our meeting in Bangladesh, and the Centre for Health Policy at the University of the Witwatersrand for hosting our meeting in Johannesburg.

We also appreciate the help given by our colleagues in the UN Millennium Project Secretariat, especially John McArthur, Margaret Kruk, and Stan Bernstein, who provided input, support, and guidance throughout the formulation of this report. The members of other task forces who joined with us in the cross-task force working groups on health systems and on sexual and reproductive health and rights have helped ensure that the issues that matter for maternal health and child health ultimately matter for the entire Millennium Project as well.

At Columbia University, we thank our colleagues in the Averting Maternal Death and Disability project for commenting on drafts and providing background data. We also thank graduate research assistants Perry Brothers, Ann Drobnik, and Christal Stone for their assistance over the three years of the project.

Finally, here's to our Administrative Coordinator, Rana Barar. We thank her for her unbelievable efficiency, unfailing good humor, and consistent dedication and support throughout this entire project.





Who's got the power? Transforming Health Systems for Women and Children

What kind of world do we want to live in? The Millennium Declaration lays out a vision that links poverty reduction and development, human rights and democracy, protection of the environment, and peace and security. Like many proclamations before it, the Declaration is cast in soaring, inspirational language. Its goals are lofty. Its hopes are high. But are we serious? Does the global community, particularly those who hold power in countries, both rich and poor, have the courage to make the decisions, to challenge the status quo, to guide the transformation process necessary to advance this vision? Will those whose lives and health depend on these actions have the space, the leverage, and the will to demand and ensure that they do?

The state of children's health and women's health in the world today can be described through data and statistics that catalogue death, disability, and suffering. On this score alone the picture is "staggering," to quote the World Bank; "dire," to quote the United States Agency for International Development (USAID); "a human disaster," to quote the World Health Organization (WHO); and a "health emergency," to quote the African Union (Konare 2004; USAID 2004; Wagstaff and Claeson 2004; WHO 2003).

The technical interventions that could prevent or treat the vast majority of conditions that kill children and women of reproductive age and enable all people to protect and promote their health – and so, theoretically, enable all countries to meet the Millennium Development Goals (MDGs) – can be identified. There is strong consensus among health experts: effective health interventions exist. They are well known and well accepted. They are generally simple and low-tech. They are even cost-effective.

Yet vast swathes of the world's population do not benefit from them. For hundreds of millions of people, a huge proportion of whom live in sub-Saharan

Africa and South Asia, the health systems that could and should make effective interventions available, accessible, and utilized are in crisis – a crisis ranging from serious dysfunction to total collapse. And behind the failure of health systems lies a deeper, structural crisis, symbolized by a development system that permits its own glowing rhetoric to convert the pressure for real change into a managerial program of technical adjustments.

The result is a terrible disconnect between the dominant development models and the brutal realities that people face in their daily lives. Mainstream development practice is effectively delinked from the broader economic and political forces that have generated a level of inequity, exclusion, divisiveness, and insecurity that will not be bottled up and stashed away. Too many bold attempts at change have been neutralized: the damage now lies exposed.

The chasm between what we know and what we do, between our ability to end poverty, despair, and destruction and our timid, often contradictory efforts to do so lies at the heart of the problem. The targets and indicators set by the Goals are framed in technical, results-oriented terms. But the response must not be simply a technical one, for the challenge posed by the MDGs is deeply and fundamentally political. It is about access to and distribution of power and resources: within and between countries; in the structures of global governance; and in the intimate spaces of families, households, and

communities. Until we face up to the fundamental anchoring of health status, health systems, and health policy in these dynamics, our seriousness about achieving the Goals can be legitimately questioned.

Indeed, some have scoffed at the ambitious targets for child mortality and maternal health set by the MDGs. But the Goals are attainable. There are inspiring examples of success. Huge reservoirs of skill and determination exist in every part of the world. The financial costs of meeting the maternal and child health Goals are dwarfed by what the world spends on

preparing for and waging war. Indeed, they are dwarfed by the enormous sums already spent on interventions that do not reach those who need them – and by the terrible price being paid in human lives as a result.

The obstacles loom large as well. The impulse to continue business as usual may be giving way to talk about transcending business as usual, but talk is not action. Sometimes talk delays or deflates action; erects a wall of words that effectively blocks action. The Goals crack open a space in the wall. The task force hopes to help forge a pathway through it. But in the end,



it is those who hold power and the people who demand their accountability who must take the first steps.

This report assesses progress toward Goal 4 (on child mortality) and Goal 5 (on maternal health) and proposes best strategies for reaching them. The report builds on a strong foundation of



epidemiological data and analysis generated over the past several decades. This evidence base provides an increasingly refined picture of who dies or suffers poor health and why, and gives crucial information about the efficacy and safety of interventions to address those causes. It also generates insights about the effectiveness of different types of delivery systems for making interventions available, accessible, appropriate, and affordable.

This evidence base must be increased and strengthened. But epidemiological data and intervention-specific assessments of cost-effectiveness cannot by themselves provide all the answers for achieving the maternal and child health Goals, because they capture only some dimensions of a highly textured problem. In addition to the epidemiology, therefore, the task force puts forward a second line of analysis that focuses on health systems and their unique role in reducing poverty and promoting democratic development. It demonstrates that functioning, responsive health systems are an essential prerequisite for addressing maternal and child health issues on a large scale and in a sustainable way – in short, for meeting the MDGs.

To address health systems, the report draws on research from multiple disciplines, including epidemiology, economics and political economy, anthropology and the behavioral sciences, law, and policy analysis. Although the task force joins the call for increased research into health systems to generate a deeper and stronger evidence base (The Lancet 2004; Ministerial Summit on Health Research 2004), we explicitly recognize that policy responses do not just follow automatically from data. Rather, policymakers face choices. And the choices they make must be fundamentally grounded in the values and principles that members of the global community have agreed should govern the world that we build together.

The task force therefore takes its first principles – equity and human rights – from the Millennium Declaration and the long line of international declarations, binding treaties, and national commitments on which it is based. It demonstrates how these principles, guided by the scientific evidence, can be translated into specific steps, clear priorities, policy directions, and program choices. The aim of this report is to set out the basic framework of the strategy that results.

A rights-based approach

'Women and children' – a tag line for vulnerability, an SOS for rescue, a trigger for pangs of guilt. Change must begin right there. The MDGs are not a charity ball. The women and children who make up the statistics that drive the MDGs are citizens of their countries and of the world. They are the present and future workers in their economies, caregivers of their families, stewards of the environment, innovators of technology. They are human beings. They have rights – entitlements to the conditions, including access to healthcare, that will enable them to protect and promote their health; to participate meaningfully in the decisions that affect their lives; and to demand accountability from the people and institutions whose duty it is to take steps to fulfill those rights.

What should those steps be? Indisputably, poor health is connected to broader social, economic, and environmental conditions, some of which must be addressed from outside the health sector. Meeting other MDGs, particularly the Goals on gender empowerment, education, water, hunger, and income poverty, can have a powerful effect on the health and survival of all people, including women and children. In some cases, the causes are direct (clean water directly reduces infection, for example), but in many other cases, the impact of external factors is mediated through the health sector. For example, advances in women's equality and empowerment mean that women can more readily make the decision to access emergency care when they suffer obstetric complications or when their children fall seriously ill.

Hence health sector interventions – ideally in synergy with other MDG strategies outside the health sector – are critical to achieving Goals 4 and 5. Health sector interventions can also have significant effects on many other aspects of development and poverty reduction².

The causes of mortality and poor health are known

Approximately 10.8 million children under the age of five die each year, 4 million of them in their first month of life (Black et al. 2003). While child mortality has steadily declined in the past two decades, progress on key indicators has started to slow, and in parts of sub-Saharan Africa, child mortality is on the rise. The greatest part of the mortality decline since the 1970s is attributable to reduction in deaths from diarrheal diseases and vaccine-preventable conditions in children under five. Other major killers of children, such as acute respiratory infection, have shown far less reduction;



² This task force report limits its focus and recommendations to the health sector. For the full complement of strategies to meet the maternal health and child health Goals, these recommendations should be linked to the recommendations of other task forces and to the report: *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* (UN Millennium Project 2005).



malaria mortality has been increasing, especially in sub-Saharan Africa, and neonatal mortality has remained essentially unchanged. Therefore, as other causes of under-five mortality decline, neonatal mortality accounts for an increasing proportion of all childhood deaths. Malnutrition in children is a contributing factor to more than half of all child mortality, and malnutrition in mothers accounts for a substantial proportion of neonatal mortality.

For maternal mortality – the death of women in pregnancy and childbirth – progress has been even more elusive. Despite 15 years of the global ‘Safe Motherhood Initiative’, overall levels of maternal mortality are believed to have remained unchanged. The latest estimate of deaths stands at about 530,000 a year (WHO, UNICEF, and UNFPA 2004). A handful of countries have experienced remarkable drops in the maternal mortality ratio³, an inspiring reminder that with the right policies and conditions in place, dramatic and rapid progress is possible. But in the great majority of high-mortality countries, where most maternal deaths occur, there has been little change. In some countries, where levels of HIV/AIDS and malaria are high and growing, the number of maternal deaths and the maternal mortality ratio are thought to have increased (McIntyre 2003). And the half million maternal deaths are only the tip of the iceberg: another 8 million women each year suffer complications from pregnancy and childbirth that can last their lifetime.

Other aspects of maternal health present a mixed picture. While the global total fertility rate has declined dramatically – from 5.0 births per woman in 1960 to 2.7 in 2001 – an estimated 201 million women who wish to space or limit their childbearing are not using effective contraception that would enable them to do so. The result is about 70–80 million unintended pregnancies each year in developing countries alone (Singh et al. 2003).

Meanwhile, violence continues to shatter the lives of women in every part of the globe. In addition, sexually transmitted infections, including

³ The WHO definition of a maternal death is “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes” (WHO 1992). The maternal mortality ratio is the number of maternal deaths per 100,000 live births. The maternal mortality ratio is a measure of the risk of dying once a woman is already pregnant.



HIV/AIDS, ravage whole communities, with disastrous effects on families and societies. The 13 million 'AIDS orphans' around the world – children who have lost one or both parents to AIDS – are testament to this fact.

Full access to effective interventions would dramatically reduce mortality

The primary health interventions to address most of these conditions are known. The Bellagio Study Group on Child Survival estimated that with 99 percent coverage of proven effective interventions, 63 percent of child mortality would be averted (Jones et al. 2003; Figure 1). The World Bank estimated that if all women had access to the interventions for addressing complications of pregnancy and childbirth, especially to emergency obstetric care, 74 percent of maternal deaths could be averted (Wagstaff and Claeson 2004; Figure 2). Moreover, universal access to sexual and reproductive health information and services would have far-reaching effects for both the maternal health and child health Goals and for virtually every other Goal, including those for HIV/AIDS, gender, education, environment, hunger, and income poverty.

If we know the causes of most child and maternal deaths and disabilities, and we have the interventions to prevent or treat those causes, then why have these problems been so intractable? It is simple enough to call for the massive scaling up of these interventions, but scaling up is not just a process of multiplication: of more providers, more drugs, more facilities in more places. Ensuring that healthcare is accessible to – and used by – all those who need it also means tackling the social, economic, and political context in which people live and in which health institutions are embedded. Both dimensions – concrete operational issues and wider contextual issues – need sustained attention and investment.

Figure 1.
Full use of existing
interventions would
dramatically cut
child deaths

Source: Adapted from
Jones et al. 2003;
neonatal deaths based on
Save the Children 2001.

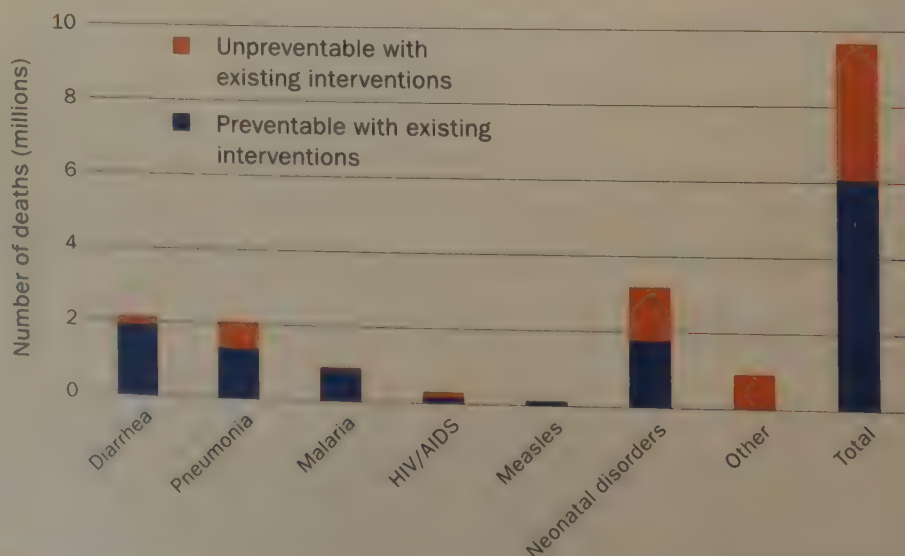
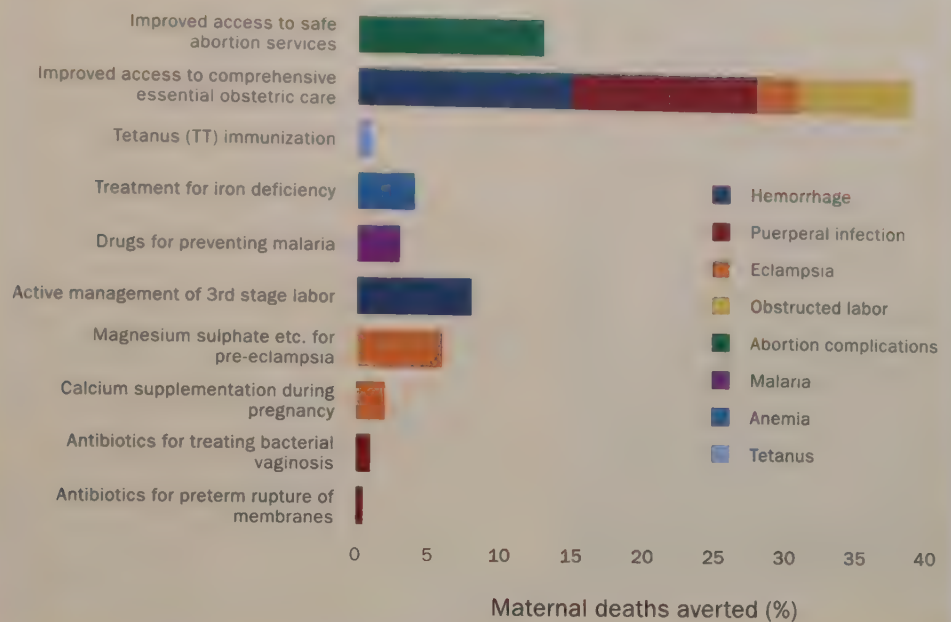


Figure 2.
Full use of
existing services
would dramatically
reduce maternal
deaths

Source: Adapted from Wagstaff
and Claeson 2004



Technical dimensions to scaling up

The task force recommends that highest priority be given to strengthening the primary healthcare system, from community-based interventions to the first referral-level facility at which emergency obstetric care is available. This implies a focus on the district level where, in many countries, critical planning, budgeting, and implementation decisions are made. There is no single blueprint for how a health system at this level should be organized. In the fields of maternal, child, and reproductive health, multiple strategies have proven successful. Based on these experiences and on a large body of scientific data, the task force suggests basic principles and guidelines that countries should consider in developing detailed plans for meeting the Goals.

Addressing maternal and neonatal deaths

The ideal scenario is this: as part of an integrated primary healthcare system, every birth, whether it takes place at home or in a facility, is attended by a skilled birth attendant, backed up by facilities that can provide emergency obstetric care and essential newborn care, and by a functioning referral system that ensures timely access to the appropriate level of services in case of life-threatening complications. On the way to that ideal, countries must make hard choices about setting priorities. One challenge is to determine whether there are immediate interim steps that can address some significant proportion of mortality while simultaneously strengthening the foundations of the health system so that ultimately the optimal level of care is provided for every woman and newborn.



The most appropriate interim steps for newborn care may well be different from the most appropriate interim steps for addressing maternal mortality. For newborns a substantial proportion of life-threatening conditions can be addressed within the community, by healthcare workers with only a few months of training (Box 1).

But healthcare providers with this level of skill will not be able to effectively address obstetric complications experienced by the woman giving birth. These are the situations that lead to the deaths of women and often their babies as well. Such emergencies must be handled by skilled professionals with the supplies, equipment, and healthcare teams that are available only in health facilities that provide emergency obstetric care.

A number of interventions, such as malaria prophylaxis and active management of third-stage labor, can have some impact on maternal mortality by preventing complications. These interventions certainly should be provided as part of routine antenatal and delivery care, and research to improve their safety and effectiveness – research on uniject oxytocin or misoprostol, for example – should be encouraged. Complications of unsafe abortion, which now account for some 13 percent of maternal deaths globally, could also be prevented through access to contraception and safe abortion services.

However, most obstetric complications occur unexpectedly around the time of delivery in women with no known risk factors, striking about 15 percent of all pregnant women. Therefore, to meet the MDG target of reducing the maternal mortality ratio by 75 percent by 2015, it is critical that countries now put priority focus on ensuring that women who experience life-threatening complications can and do receive the emergency obstetric care that can save their lives (Box 2). This necessarily means tackling the facility-based health system and its interaction with the communities and individuals it serves. Both supply-side factors (the availability of high-quality services) and demand-side factors (the barriers to appropriate utilization) are relevant, but initiatives to address them in any given geographic area must be carefully sequenced. A rights-based approach will pay particular attention to the link between supply and demand, establishing constructive accountability mechanisms that involve the community to ensure consistent 24 hours-a-day, 7 days-a-week functioning, equitable access, and high-quality, responsive care.

Addressing child mortality

For children, much can be accomplished without the involvement of the health system. Improved water supplies, sanitation and a reduction in indoor air pollution could significantly reduce the incidence of some of the more common diseases of childhood. Exclusive breastfeeding for the first six months and

Box 1.
Priority
interventions
for improving
neonatal survival

Recent and ongoing work has resulted in the identification of a number of evidence-based interventions that can prevent neonatal deaths (Bhutta et al. 2005; Darmstadt et al. 2005). These interventions can be divided into three groups: a universal package, which should be available in all settings; situational interventions, for use in areas with particular epidemiological characteristics, such as a high prevalence of malaria; and additional interventions, which could be implemented where stronger health systems capable of supporting them exist (Table 2). The new estimates show that universal (99 percent) coverage of these interventions could avert 41–72 percent of global neonatal deaths (Darmstadt et al. 2005).

Table 2. Evidence-based interventions that can prevent neonatal deaths

Timing of intervention	Intervention		
	Universal coverage	Situational interventions	Additional interventions
Antenatal	<ul style="list-style-type: none"> • Antenatal care package <ul style="list-style-type: none"> – Tetanus toxoid immunization – Detection and management of pregnancy-induced hypertension (PIH)/eclampsia – Birth and emergency preparedness – Syphilis screening and treatment – Breastfeeding promotion 	<ul style="list-style-type: none"> • Malaria presumptive intermittent therapy • Prevention of mother-to-child transmission (PMTCT) of HIV^a 	<ul style="list-style-type: none"> • Peri-conceptual folic acid supplementation • Detection and treatment of asymptomatic bacteriuria • Antibiotics for preterm premature rupture of membranes • Antenatal corticosteroids for preterm delivery
Intra-partum	<ul style="list-style-type: none"> • Clean delivery practices • Newborn resuscitation • Skilled obstetric care • Comprehensive emergency obstetric care 		
Postnatal	<ul style="list-style-type: none"> • Essential care package <ul style="list-style-type: none"> – Hygienic cord and skin care – Hypothermia prevention and management – Breastfeeding promotion (immediate, exclusive) • Care of low birth weight (LBW) infants (extra attention to warmth, hygiene, feeding) • Community case management for pneumonia • Emergency management for sepsis and extreme LBW 	<ul style="list-style-type: none"> • PMTCT of HIV^a 	

Source: Darmstadt et al. 2005.

^a HIV infection is not a cause of neonatal deaths, but the antenatal and postnatal periods are critical entry points for PMTCT interventions.

Box 2.
Emergency
obstetric care

Emergency obstetric care is generally categorized as either basic or comprehensive care, depending on the functions the facility performs (Table 3). UN guidelines recommend a minimum of one comprehensive emergency obstetric care facility and four basic emergency obstetric care facilities per 500,000 population. To meet the Goals, high-mortality countries must substantially improve access to emergency obstetric care. It is therefore critical that the indicators for tracking progress include a measure that is sensitive to coverage of emergency obstetric care. The task force proposes coverage of emergency obstetric care facilities (comprehensive and basic) per 500,000 population, as an additional indicator.

One input that is vital to the effective functioning of emergency obstetric care facilities is the presence of skilled birth attendants. The WHO/ICM/FIGO definition of a skilled attendant is an accredited health professional who can manage normal deliveries and can identify, manage, and refer women and newborns with complications (WHO 2004). Whether skilled attendants are based in the community or in a facility, their ability to manage the complications that kill women depends on their ability to access a functioning health system. Initiatives to expand the number of skilled birth attendants must therefore be effectively linked to and properly sequenced with initiatives to strengthen the health system (especially emergency obstetric care services) and improve workforce policies.

Table 3. Functions of basic and comprehensive emergency obstetric care services

Basic services	Comprehensive services
Administer parenteral ^a antibiotics	All services included in basic emergency obstetric care plus:
Administer parenteral ^a oxytocic drugs	Perform surgery (cesarean section)
Administer parenteral ^a anticonvulsants for pre-eclampsia and eclampsia	Perform blood transfusion
Perform manual removal of retained products (for example, manual vacuum aspiration)	
Perform assisted vaginal delivery	

^aBy injection or intravenous infusion. Source: UNICEF, WHO, and UNFPA 1997.

appropriate complementary feeding could prevent almost 20 percent of childhood deaths in the 42 countries where 90 percent of those deaths occur. Birth spacing has been estimated to reduce child mortality by 19 percent in India and 11 percent in Nigeria (Jones et al. 2003). Other simple strategies, such as providing information on how to recognize the early signs of potentially fatal illnesses and where to seek care for them, are also essential (Box 3).

Bringing appropriate curative care into the community would help overcome the low utilization rates of health facilities. New policies allowing closer-to-client services, such as the use of antibiotics by community-level healthcare workers – recently recommended by WHO and the United

Box 3.
Twelve simple
family health
practices

Source: www.who.int/child-adolescent-health/PREVENTION/12_key.htm

Child survival, growth, and development starts in the family. A number of simple steps can be taken to raise the chances of child survival. Evidence from WHO suggests these 12 simple practices can prevent illness or reduce the likelihood of complications:

1. Exclusively breastfeed infants for at least six months. (HIV-positive mothers require counseling about alternatives to breastfeeding.)
2. Starting at about six months, feed children freshly prepared energy- and nutrient-rich complementary foods, while continuing to breastfeed for up to two years or longer.
3. Ensure that children receive adequate amounts of micronutrients (particularly vitamin A and iron), either in their diet or through supplements.
4. Dispose of feces, including children's feces, safely, and wash hands after defecation, before preparing meals, and before feeding children.
5. Take children as scheduled to complete a full course of immunizations (BCG, DPT, OPV, and measles) before their first birthday.
6. Protect children in malaria-endemic areas by ensuring that they sleep under insecticide-treated bednets.
7. Promote mental and social development by responding to a child's needs for care through talking, playing, and providing a stimulating environment.
8. Continue to feed and offer additional fluids, including breast-milk, to children when they are sick.
9. Give sick children appropriate home treatment for infections.
10. Recognize when sick children need treatment outside the home and seek care from appropriate providers.
11. Follow the health worker's advice about treatment, follow-up, and referral.
12. Ensure that every pregnant woman has adequate antenatal, delivery, and postpartum care. This includes having at least four antenatal visits from an appropriate healthcare provider and receiving the recommended doses of tetanus vaccination. The mother also needs support from her family and community in seeking care at the time of delivery and during the postpartum and lactation period.

To provide this care, families need knowledge, skills, motivation, and support, much of which can be provided by their communities. They also need support from the health system, in the form of accessible clinics and responsive services, and healthcare workers able to give effective advice, drugs, and more complex treatments when necessary.

Nations Children's Fund (UNICEF), would be welcome. Development of new and more heat-stable vaccines and new antibiotics and other drugs that can be given in shorter and easier-to-administer courses would also help.

But peripheral workers will always need close supervision and support from higher-level health professionals, and both they and mothers will need to be able to access well-staffed and well-supplied facilities for outpatient care. First-level referral hospitals are indispensable for treating severe illnesses. In other words, further reductions in child mortality must rely heavily on an accessible and competent health system that is actively involved through the entire range of primary healthcare services. Recent evaluations of the Integrated Management

of Childhood Illness (IMCI) strategy supported by WHO and UNICEF and implemented widely throughout the world have indicated that good results are obtained only when health systems are strong.

Sexual and reproductive health

A comprehensive, functioning district health system is critical for ensuring full access to sexual and reproductive health information and services which, together with good nutrition, form the foundation of good health for women and children. This includes access to contraception, since control over the number and spacing of children can have a profound impact on the health and well-being of both women and their children. It also includes safe abortion services, as well as information and services for preventing and treating sexually transmitted infections, including HIV/AIDS. Indeed, for HIV/AIDS interventions to be maximally effective they should be integrated

Box 4. Policies and interventions to address sexual and reproductive health needs

Source: UN Millennium
Project 2005.

Sexual and reproductive health encompasses both an analytic and a programmatic framework, based on a human rights approach, rooted in stronger health systems, supported by communities, and accompanied by complementary interventions in other sectors.

Reproductive health approaches recognize the importance of a full spectrum of prevention, treatment, and care, and the linkages between these services. However reproductive health requires more than simply delivering services and information to prevent disease and reduce risk. It includes:

- Family planning, including access to modern contraceptives and informed and voluntary choice of family planning methods.
- Antenatal, postnatal, and delivery services, including emergency obstetric care.
- Postabortion care and, where permitted by law, access to safe abortion.
- A continuum of prevention, treatment, and care for HIV/AIDS and other sexually transmitted infections.
- Prevention, surveillance, and care for gender-based violence.
- Action against harmful traditional practices, such as female genital mutilation and early and coerced marriage.
- Information and services for underserved populations, including diverse groups of adolescents, people in emergency situations, and men (Singh et al. 2003).

There are numerous channels through which to integrate sexual and reproductive health services in a strengthened health system. For example, maternal and child health services can provide an opportunity for family planning information programs, referrals, and services. HIV prevention can be effectively linked with other reproductive health information and service interventions. Health system contacts for abortion, where permitted by law, and for treating postabortion complications also provide entry points for family planning services to reduce the incidence of recourse to abortion. Expanding the scale of family planning service delivery should include a range of contraceptive options to meet the needs of specific populations and to accommodate choice and appropriate method-switching.

into sexual and reproductive health services, since this is where most women access healthcare.

Adolescents deserve special attention with services tailored to meet their needs, including the differing needs of married and unmarried adolescents. As the largest cohort – 1 billion strong – ever to make the transition from childhood to adulthood, today's adolescents need special consideration if we are to meet the Goals in a long-term, sustainable way.

Crucial changes in human resource policies

One enormous barrier to providing these interventions is the lack of adequately trained providers deployed throughout the health system and across geographic locations. This problem has been intensified in recent years by the massive migration of health professionals from poor countries to rich countries (the so-called 'brain drain'); by macroeconomic policies that impose hiring freezes and salary caps; and by HIV/AIDS, which has decimated the health workforce in some high-prevalence countries.

To address the crisis in human resources, policymakers should take several key steps:

- Revise laws and practices, including those related to 'scope of profession,' to enable mid-level providers, such as midwives, surgical technicians, and general medical practitioners, to perform procedures they can be trained to do safely and effectively but that are currently restricted to specialist physicians. These procedures include all basic emergency obstetric care functions, anesthesia and even cesarean section.
- Enable community health workers to perform vital interventions for child and newborn health and reproductive health within the community, with supportive supervision from the health system.
- Substantially increase salaries and improve career paths and working conditions of health providers.

However, simply identifying these kinds of interventions gets us only marginally closer to the kind of functioning health system that is needed to meet the Goals. The wider context in which health services are delivered and accessed must also be addressed.



Health systems are core social institutions

Social, economic and political conditions present complex environments that resist formulaic solutions, particularly when imposed from outside and above. But too often recognition of this fact spells paralysis or, even worse, new rounds of technical solutions designed to dodge the issues altogether.

This report focuses on three kinds of interconnected challenges that can provide meaningful entry points to address the broader context, and which are themselves high-priority issues essential to MDG strategies: health inequity and the experience of poverty; health systems as social institutions that are greater than the sum of the medical interventions they deliver; and international aid levels and the development policies and processes that determine them.



Fundamental changes are needed

The disparity between rich and poor countries in terms of maternal mortality is dramatic. In some parts of sub-Saharan Africa women have a 1 in 6 chance of dying in childbirth, while in parts of North America and Europe, lifetime risk is as low as 1 in 8,700 – and maternal mortality has virtually disappeared as a public health problem (WHO, UNICEF, and UNFPA 2001).

Although the disparities in child mortality are less dramatic, nearly all child deaths occur in low- and middle-income countries, 75 percent occur in sub-Saharan Africa and South Asia

alone. For both maternal and child health, sub-Saharan Africa (with the highest mortality rates) and South Asia (with the largest number of deaths) form the two epicenters of the crisis.

Less well documented, and far less understood, are the massive disparities that occur within high-mortality countries. Differences in health are not random; a growing body of research demonstrates that the disparities are systematic and follow underlying hierarchies of social disadvantage. The magnitude of these inequities varies across countries, health conditions, and health interventions. Disparities by wealth, geographic area, and gender have been most widely documented, but there are other lines of social disadvantage as well, including race and ethnicity, urban/rural status, and linguistic or religious divisions.

To some extent the disparity in health status stems from disparities in living and working conditions that fall outside the health sector. But it is critical to recognize that social and economic disadvantages also directly influence access to and utilization of healthcare, as well as the patterns of health spending. While the health system could and should function as

a safety net, providing care to those who need it most, all too often the reverse is true: socially excluded groups do not have access to badly needed care, despite their higher burden of disease, and when they are able to access care it often involves catastrophic costs that deepen their impoverishment.

The implication for MDG strategies is clear: a trickle-down approach to addressing disparities will not work. The fact that a particular health intervention is used to prevent or treat a disease that is more prevalent among the poor does not mean that the poor will be the ones who benefit from increased spending on that intervention. In fact, without specific attention, just the opposite is likely to happen. Therefore strategies to meet the Goals must explicitly address not only the poor and marginalized, but inequity – the gap itself.

Countries – including health authorities at the local and even the facility level – must document and understand disparities in health status and the utilization of healthcare. Although there is enormous room for new work and innovation in health equity research, a wealth of information already lies buried in the data generated by current health information systems (Wirth et al. 2004). Progress in closing the equity gap can and should be monitored through the use of this information as an intrinsic part of the MDG initiative. The task force therefore recommends that the maternal health and child health targets be modified so that they are equity-sensitive. These same monitoring processes can also feed directly into human rights monitoring at the international and national levels, since nondiscrimination is a cross-cutting norm codified in human rights law.

Gathering information on inequity is one thing, a far more complex question is exactly which kinds of interventions will best address inequity. The answer will be context-specific, and the process by which the answer is formulated – ideally, a process that includes the marginalized in a meaningful way – will be intrinsic to the solution. The overriding recommendation of the task force is that so-called ‘pro-poor’ strategies should not deal only with the symptoms; they must deal meaningfully with the roots of inequity. Much writing in the international health field in recent years has referred to pro-poor interventions, sometimes with little thought about whether such interventions are necessarily ‘pro-equity’ or even ‘anti-poverty.’ Sometimes interventions do need to be carefully targeted to geographic areas or populations that are disadvantaged. However, if the fundamental sources of inequity within the health system are not acknowledged and addressed, the danger is that targeted interventions will stigmatize populations or breed little more



Box 5. Defining health systems

This report adopts the WHO definition of the health system: “all the activities whose primary purpose is to promote, restore, or maintain health” (WHO 2000). This includes interventions at both the household and community level, and the outreach that supports them, as well as the facility-based system and broader public health interventions, such as food fortification and anti-smoking campaigns.

It includes all categories of providers: public and private, formal and informal, for-profit and not-for-profit, allopathic, and indigenous. It also includes such mechanisms as insurance by which the system is financed, as well as the various regulatory authorities and professional bodies that are meant to be the ‘stewards’ of the system. Equally importantly, health systems are a vital part of the social fabric of any society. As such, they “are not only producers of health and healthcare, but they are also purveyors of a wider set of societal norms and values” (Gilson 2003).

than cynicism. Pro-poor interventions deployed around a core of a deeply inequitable structure are insufficient.

Health systems play a central role in democratic development, poverty reduction and fulfillment of human rights

To meet the Goals, the very structure and functioning of the health system must be considered (Box 5). One objective of the health system is, of course, to ensure equitable access to the technical interventions necessary to promote health and treat disease. But development planners and government authorities have often failed to grasp the extent to which abusive, marginalizing, or exclusionary treatment by the health system has come to define the very experience of being poor. Moreover, they have often failed to grasp that the converse is also true: the health system as a core social institution, part of the very fabric of social and civic life, has enormous potential to contribute to democratic development.

Health claims – claims of entitlement to healthcare and enabling conditions – are assets of citizenship. Their effective assertion and vindication through the operation of the health system helps build a human rights culture and a stronger, more democratic society (Mackintosh and Tibandebage 2004).

Taking redistribution seriously

Our ability to meet the MDGs turns on our ability to think differently and act differently about health systems. The status quo is unacceptable, in multiple respects:

- The fragile and fragmented health systems that now exist are unable to ensure availability, access, and utilization of key health interventions in sufficient volume and quality to meet the Goals.
- The costs individuals incur in managing (or failing to manage) their health are often catastrophic, thus deepening poverty.



- As core social institutions, dysfunctional and abusive health systems intensify exclusion, voicelessness, and inequity while simultaneously defaulting on their potential – and obligation – to fulfill individuals' rights and to contribute to the building of equitable, democratic societies.

The approach put forward in this report responds to the dominant policy packages that have been promoted for health sector reform over the past two decades – and to the realities that have resulted on the ground. These prescriptions for reform have been based on the fundamental conviction that healthcare is best delivered to populations through competitive markets. To create such markets, the prevailing approach converts healthcare into a marketable commodity, that is, into a product or service to be bought and sold. It encourages the development of a competition-driven private sector to deliver health services on a for-profit basis (and in practice also encourages private, non-profit providers, such as NGOs and church-owned facilities), and tries to expand the choices available to healthcare consumers, who are assumed to make optimal decisions for themselves in seeking healthcare.

This basic approach to the health sector, championed largely by donors, has been part of a broader strategy for poorly performing public sector institutions – a strategy that is ideologically opposed to a strong state presence. The strategy minimizes the role and, in practice, the legitimacy of the state.

Even the most ardent health-sector reformers, however, recognize that market-based reforms based on the commodification of healthcare will end up failing to reach the poor, who simply do not have sufficient cash or other assets to purchase the care they need. They also recognize that such 'market failure' means that a segment of



the population will continue to suffer poor health, which, especially in the case of infectious diseases such as HIV/AIDS and severe acute respiratory syndrome (SARS), has clear externalities – that is, effects on society beyond the poor health of the individuals unable to purchase healthcare. Thus even strongly market-based health reforms see a role for public-sector services. In this model, the central role of the public sector is to 'fill the gap' by providing a minimum level of essential services – often formulated as an 'essential services package' – for the poor. Governments also act as the 'stewards' of the system, setting policies, law, and regulations, even if they do not deliver services directly.

Health sector reforms were expected to increase both efficiency (through markets) and equity (through the broader reach of an invigorated private sector for those who could pay and a 'residual' public sector for those who could not). That was the theory; the reality has been far different and, of course, rather varied as well. But, quite systematically, these reforms have been experienced as deeply unequalizing (Mackintosh 2001). Moreover, the theoretical neatness of discrete public and private sectors, each with its own role, pertains almost nowhere (Bloom and Standing 2001). People rich and poor face a pluralistic market with a wide and chaotic array of services of wildly varying quality that in virtually all cases require outlays of cash to access, even in the public sector where fee-exemption schemes are in place.

The overall weakening of the state has left it unable to perform the regulatory and governance functions on which a market-based system depends (in many cases it was not strong enough to perform these functions well in the first place). That failure, and the chaos and inequity that result, intensify the problem: they further erode the state's legitimacy in the eyes of both the people who make up the health system and the people who look to it for managing health and disease – quite often for matters of life and death. Confronting this reality, the task force puts forward the outlines of a different approach to health systems (Table 4).

Table 4.
Task force
approach to
health systems

Item	Conventional approach	Task force approach
Primary unit of analysis	Specific diseases or health conditions, with focus on individual risk factors	Health system as core social institution
Driving rationale in structuring the health system	Commercialization and creation of markets, seeking financial sustainability and efficiency through the private sector	Inclusion and equity, through cross-subsidization and redistribution across the system
Patients/users	Consumers with preferences	Citizens with entitlements and rights
Role of state	Gap-filler where market failure occurs	Duty-bearer obligated to ensure redistribution and social solidarity rather than segmentation that legitimizes exclusion and inequity
Equity strategy	Pro-poor targeting	Structural change to promote inclusion

The conventional and the proposed approaches are not mutually exclusive. Indeed, many elements of the conventional approach, such as burden of disease assessments, user preferences, or even market operations, are also important elements of the task force approach. But the task force advocates a basic shift in perspective and mindset. That shift begins with the need to understand the nature and functioning of the health system differently, in effect to change the primary unit of analysis from specific diseases to health systems as core social institutions.

The proposed approach also adopts a different view of the role of the state. It does not propose a particular model for state involvement in service delivery, recognizing that there are many different routes to and providers of excellent healthcare. But it does propose a different understanding of state responsibility and obligation in relation to health, and a different understanding of the role of health systems in the overall process of democratic development. Among other things, the approach places increased importance on equity, seeing it as a central objective of health policy. This means taking seriously the need for redistribution within the health system.

Redistribution is defined as: "all social processes that create increasingly inclusive or egalitarian access to resources" (Mackintosh and Tibandebage 2004). The crux of the problem is not just how to target resources to a population that has low access or utilization rates (often labeled a 'pro-poor' intervention), but rather how to create a system that encourages, supports, and sustains increasing inclusion and equity, that is, redistribution.

To do that, the task force puts forward three principles to guide context-specific policymaking and offers supporting rationales and specific possible policy interventions that derive from each (Table 5). These principles are:

1. *Strengthening the legitimacy of the state.*
2. *Preventing excessive segmentation by enhancing norms of collaboration to improve services in both public and private sectors.*
3. *Strengthening the voice and power of the poor and marginalized to assert claims.*

Meeting the Goals requires increased investment

Current levels of expenditure are simply not enough to effect the changes necessary to meet the Goals. In the poorest countries of sub-Saharan Africa, health expenditures are in the range of US\$1–10 per capita, with a substantial proportion coming out of the pockets of users. In many cases the costs of healthcare are catastrophic, pushing already poor people deeper into poverty. In 2001 the Commission on Macroeconomics and Health determined that a basic package of primary healthcare would cost about US\$34 per capita per year (Commission on Macroeconomics and Health 2001). It is the obligation of national governments and the international community to ensure that such amounts are available and spent to improve and safeguard health.

Table 5. Principles of redistribution, policy responses and rationale

Principle	Policy interventions	Rationale
1. Strengthen government legitimacy	<ul style="list-style-type: none"> • Improve access to health services through progressive financing mechanisms, and improve the quality of care provided by the public sector • Reinforce the commitment to health as a right • Establish transparent and participatory decision-making processes • Improve resource allocation to underserved areas based on measures of equity • Create transparency in allocation and expenditure 	<p>Such policies:</p> <ul style="list-style-type: none"> • Address inequity by improving access for the poor and marginalized • Signal commitment to inclusiveness and redistribution • Demonstrate procedural fairness • Increase trust and strengthen government's ability to regulate effectively • Enhance the legitimacy required for the ministry of health to improve its status amongst other government departments
2. Prevent excessive segmentation	<ul style="list-style-type: none"> • Establish collaborative regulation, ensuring agreed explicit rules, encouraging informal relationships and using regulation to check the power of interest groups • Share resources including information and technology • Engage in joint planning activities • Use financing tools to discourage segmentation • Reinforce quality in both public and private sectors 	<p>Such policies:</p> <ul style="list-style-type: none"> • Create and support collaborative professional and institutional cultures • Normalize a rights-based approach by including stakeholders • Shape markets to promote inclusion • Increase trust and communication between public and private sectors, which reduces complexity and transactions costs • Use negotiated processes to yield rules with increased legitimacy • Improve cross-subsidization by keeping those who can pay in the system • Expose the middle class to issues of the poor, rather than excluding the poor from the system
3. Strengthen the voice of the poor and marginalized	<ul style="list-style-type: none"> • Document, monitor, and publicize disparities in health status and healthcare across population groups • Provide opportunities for asserting claims • Regulate to ensure appropriate public inclusion in health institution management in both the public and private sectors • Use space opened by consumer rights movement for advocating claims • Support and encourage existing civil society organizations to help monitor facilities and providers • Ensure government mechanisms exist to improve responsiveness to claims 	<p>Such policies:</p> <ul style="list-style-type: none"> • Adopt a human rights-based approach to legitimize claims to health • Improve accountability processes • Reinforce democratic processes and good governance

The right policy environment

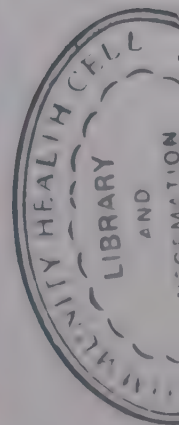
Many of the steps needed to meet the child health and maternal health Goals can begin immediately, at the national, district, and local levels. For example, inequity can be tackled by documenting disparities in specific settings and initiating local problem-solving processes. Failures in the provision of emergency obstetric care can often be fixed by focusing attention on the problem and making changes in facility-based management or logistical systems that do not require massive infusions of new money.

But the kind of transformation required to meet the Goals at the national level will necessarily entail serious revisions to the policy environment, including the processes and practices by which aid is determined and distributed (Box 6). Far too often, the best-laid plans of the health sector are quashed or neutralized when put through the wringer of national and international mechanisms. Finance and planning ministries and the officials of international financial institutions with whom they negotiate need to have a profoundly different appreciation of the importance of health and health systems for economic growth, poverty reduction, and the building of democratic societies.

The UN Millennium Project calls for poverty reduction strategies that are based on the Millennium Development Goals. In the area of health, this requires more than a list of statistics of poor maternal and child health and a statement of determination to address them. It entails making hard decisions about priorities, examining the underlying health system, and ensuring that implementation, monitoring, and accountability processes are in place.

Accountability should lie at the heart of the MDG initiative. In the end, poverty reduction and the strategies to make it happen will require meaningful participation of those whose lives and health depend on it and serious, determined, courageous action from those who have the power to initiate, sustain, and guarantee change.

Goals 4 and 5 are attainable – but not without extraordinary effort



Box 6.
Global policy
and funding
frameworks

Equitable and well-functioning health systems depend on supportive policy environments. For low-income countries, international policy and external financial support are closely intertwined – either directly, through policy conditions linked to external aid, or indirectly, from advice, assistance, or support that particular donors offer.

Non-government stakeholders have critical roles to play in promoting greater equity and long-term investments in the health system and holding government accountable for improvements in health outcomes. Civil society groups need to be included more fully in policymaking processes and in poverty and social impact analysis of health sector policies and budgets.

Some of the main strategies and recommendations are:

Strengthening policy and funding frameworks

Poverty Reduction Strategy Papers (PRSPs): Given the importance of health for poverty reduction, health ministries and other health stakeholders must engage more actively in the PRSP process. Within the PRSP framework, donors must maintain and improve their direct support to health systems, ideally through coordinated support of a national health sector strategy that is founded on principles of inclusion, equity and rights.

Medium-Term Expenditure Frameworks (MTEFs): MTEFs are likely to become even more important as donors shift toward general budget support from project or sector support for low-income governments. MTEFs should be aligned with the PRSPs and used to monitor spending in the health sector to ensure it is consistent with reaching the MDGs and other national health priorities. The international financial institutions and other donors to the health sector have a critical role in helping health ministries navigate through this challenging process.

Sector-Wide Approaches (SWAs): Despite slow and uneven progress of SWAs in the health sector, SWAs provide a broad platform for addressing fundamental problems in the health system, and a flexible framework in which health ministries can work with stakeholders to make the long-term improvements in their health systems necessary to meet the goals. In cases where general budget support is not likely to provide adequate funding for the health sector, SWAs can serve as a mechanism for development banks and other donors to continue to provide direct support to health ministries.

Addressing donor practices

Global Health Initiatives: Large private donors inject much-needed resources into health-research activities in low-income countries, mainly to combat specific diseases. But some of these initiatives can strain fragile health systems and divert healthcare workers from primary care to disease-specific activities. Health systems impact assessments, codes of conduct, and other measures are needed to ensure that these new health initiatives support rather than undermine health systems.

Donor Harmonization: Although progress is being made in several countries to harmonize donor procedures, a number of key donors operate outside them. It is imperative that donors and large international NGOs provide firm, long-term commitments to the health sector, so that ministries of health can develop longer-term investment plans.

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The Millennium Development Goals

Goal 1: Eradicate extreme poverty and hunger

Goal 2: Achieve universal primary education

Goal 3: Promote gender equality and empower women

Goal 4: Reduce child mortality

Goal 5: Improve maternal health

Goal 6: Combat HIV/AIDS, malaria and other diseases

Goal 7: Ensure environmental sustainability

Goal 8: Develop a global partnership for development

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The Millennium Development Goals, adopted at the UN Millennium Summit in 2000, are the world's targets for dramatically reducing extreme poverty in its many dimensions – income poverty, hunger, disease, exclusion, lack of infrastructure and shelter – while promoting gender equality, education, health, and environmental sustainability, all by 2015. These bold goals can be met in all parts of the world if nations follow through on their commitments to work together to meet them. Achieving the Millennium Development Goals offers the prospect of a more secure, just, and prosperous world for all.

The UN Millennium Project was commissioned by UN Secretary-General Kofi Annan to develop a practical plan of action

to meet the Millennium Development Goals. As an independent advisory body directed by Professor Jeffrey D. Sachs, the UN Millennium Project submitted its recommendations to the UN Secretary-General in January 2005.

The core of the UN Millennium Project's work has been carried out by 10 thematic task forces comprising more than 250 experts from around the world, including scientists, development practitioners, parliamentarians, policymakers, and representatives from civil society, UN agencies, the World Bank, the International Monetary Fund, and the private sector.

This report lays out the recommendations of the UN Millennium Project

Task Force on Child Health and Maternal Health. The task force recommends the rapid and equitable scale-up of such interventions as the Integrated Management of Childhood Illness, the universal provision of emergency obstetric care, access to reproductive health services, and the strengthening of health systems. This will require that health systems be seen as social institutions and that access to health services be considered a fundamental right. This bold yet practical approach will enable every country to reduce the under-five mortality rate by two-thirds and the maternal mortality ratio by three-quarters by 2015.

